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## Conclusion

### Introduction

Drawing on research in a wide range of fields in the social sciences and from feminist scholarship more generally, we distinguished in *Equality: From Theory to Action* between four main *contexts* where equality and/or inequality may be generated, the economic, political, cultural and affective systems. *Equality* contains a number of general hypotheses about inequality within each of these social systems and about the relationships between them, as well as the outline of a radical normative conception of equality, ‘equality of condition’, which can be applied either generally or to the specifics of each system. One of the core themes in *Equality* is the interaction of inequalities. Each of the main systems interact to promote or mitigate inequality along five key dimensions, namely (1) respect and recognition, (2) resources, (3) love, care and solidarity, (4) power, and (5) working and learning. The material in this book demonstrates quite clearly the multi-dimensional character of inequality within the affective system, and the ways in which inequalities in the economic, political and cultural systems impact on the affective sphere.

*Affective Equality: Who Cares?* has been primarily concerned with the empirical analysis<sup>1</sup> of equality within one aspect of the affective system; it focuses on other-centred (primary care) relations, that sphere of social life that is primarily oriented to the care of intimate others (see Chapters 2 and 3). It has examined inequalities in the distribution of love and care labouring and, to a lesser degree, in the receipt of love and care. It has also

examined the inter-relationships between inequality in the affective system and the economic, political and cultural systems with respect to love labouring, and how this generates and reinforces inequalities in the affective system itself.

In this final chapter, we utilise the *Equality* framework to summarise the main findings of this book. We also set out the implications of the findings for the social scientific understanding of caring in egalitarian terms, and for the development of normative egalitarian theory. As the studies have been premised on the primacy of emotional work in the doing and receiving of love labouring, we begin by underlining the significance of emotions for caring.

### *Emotions, Care and Equality*

Our feelings are essential to the making of personal meaning and identity (Chodorow, 1999). We are emotional as well as intellectual beings, social as well as individual. At the individual level, all people have the capacity for intimacy, attachment and caring relationships. We can all recognise and feel some sense of affiliation and concern for others and we all need, at least sometimes, to be cared for. We value the various forms of social engagement that emanate from such relations and we define ourselves in terms of them. Bonds of friendship or kinship are frequently what bring meaning, warmth and joy to life. Being deprived of the capacity to develop such supportive affective relations, or of the experience of engaging in them when one has the capacity, is therefore a serious human deprivation. The emotional experience of being cared about is also a fundamental prerequisite for human development and for flourishing. Research in psychology and psychoanalysis demonstrates how the ability to care about others is firmly located in the

development of attachment and feelings from infancy. While feelings are shaped by cultural and gender norms, they are also deeply personal and idiosyncratic (Chodorow, 1978). If the infant's needs for comfort and emotional warmth are not met with consistency at that stage in their lives, then the individual's capacity to develop into a mature human being, capable of feeling the distress and needs of others and indeed their own needs, is severely compromised. Being cared for is vitally important therefore, not just for physical survival, but because it enables us to feel and care for others throughout life.

The emotionally charged relations of solidarity, care and love help to establish a basic sense of importance, value and belonging, a sense of being appreciated, wanted and cared about. They play a vital part in enabling people to lead successful lives, and are an expression of our fundamental interdependence (Nussbaum 1995, Held 1995).

Given the primacy of love and solidarity in our lives, it is an important issue of equality, and therefore of justice, to ask who has access to, and who is denied, relations of love, care and solidarity. It is also vital to ask whether these relations are reciprocal or asymmetrical, whether they are gender, class, race and/or ability neutral, whether they are power balanced or power imbalanced, and whether societies operate in ways that help to satisfy or frustrate this human need. These are difficult questions to answer but this is the challenge we have addressed in this book.

## **Egalitarianism and Affective Inequality**

As noted in chapter 1, within egalitarian thinking across disciplines, love and care have been treated as private matters, personal affairs; they have not been regarded as subjects

of sufficient political importance to be mainstreamed in theory or empirical investigations, while the subject of solidarity has been given limited research attention. Sociological, economic, legal and political thought has focused on the public sphere, the outer spaces of life, indifferent to the fact that none of these can function without the care institutions of society (Fineman, 2004; Sevenhuijsen, 1998; Tronto, 1993). Within classical economics, no serious account has been taken traditionally of the reality of dependency for all human beings, either in childhood and at times of illness and infirmity (Badgett and Folbre, 1999). The dominant neo-classical economics tradition has been characterised by methodological individualism and the utilisation of rational choice theory, both of which work on the premise that a clear distinction exists between the public and private spheres. Sociology, like economics is a highly gendered discipline; this has led to the neglect of issues to do with the private sphere and with gender in particular (Bourdieu, 2001; Oakley, 1989, Smyth, 1987). The focus on the public sphere in sociology has meant that certain questions were not asked, or if asked, not taken seriously, and among those questions were the issues of care as work (Pettinger et al., 2005). Legal theorists also largely neglected the affective context until the arrival of feminism (Freeman, 1994). In legal theory, relationships conceptually defined as being in the private sphere have received little sustained critical attention except as they relate to the public domains of life (Fineman, 1995). Political theory has also been concerned with the ‘public’ sphere, defined primarily in terms of the coercive political relations of the state and the economic relations of market economies, and therefore with inequalities of income and wealth, status and power. Care has been treated as a separate entity from equality and justice. As Kittay (1999) and other feminists (including Fineman, 2004,

Folbre, 1994 and Lister, 1997) have observed however, the issue is not to choose between equality and care but to develop a ‘connection-based’ conception of equality that recognises that dependency is a typical condition of human life, that dependents need care, and that dependency workers – those who provide this care – need support in doing so. What needs to be recognised is the relational nature of human beings, including their profound interdependency (Gilligan, 1995).

To highlight the importance of relational and dependency-related inequalities, and to differentiate between these and economic, political and socio-cultural inequalities, in *Equality* we developed the concept of affective equality. We identified two primary forms of affective inequality: a) inequalities in the doing of love, care and solidarity work, and b) inequalities in the receipt of love, care and solidarity. We acknowledged that these two forms of affective inequality are exacerbated by other dimensions of inequality. Lack of respect and recognition for care-related work exacerbates the inequalities involved in having to take a disproportionate responsibility for the burdensome aspects of love, care and solidarity. A culture in which care work is not recognised and rewarded also disempowers and impoverishes carers of all kinds. Having a low income and limited resources, either independently of being a carer or because of it, also makes care work more burdensome. It limits options for assigning some of the care tasks to others, and may leave carers with little time for rest or even energy to enjoy the pleasurable aspects of love, care and solidarity work. Those who are assigned responsibility for love and care work are often powerless to determine the conditions under which they do this work, especially in the family sphere. Their powerlessness exacerbates the inequalities between themselves and those who are not carers by binding

them to the necessity of caring and denying them the opportunity to exercise autonomy in other spheres of life.

Inequality in the doing of love, care and solidarity work is but one side of affective inequality. Because humans are relational beings, entirely dependent on others at certain times in life, and interdependent throughout existence, being denied access to love, care and solidarity is a serious human deprivation and an inequality in itself. While it can be argued that no one can ever experience too much love, care and solidarity, it is true nonetheless that people need certain basic forms of love, care and solidarity to survive and to flourish. Those who are denied love and attention in their intimate lives, or who do not have access to secondary forms of caring, be it from friends, neighbours, kin, colleagues or important service providers (such as teachers and health workers), or who live in societies that have little solidarity in terms of the distribution of wealth and other privileges, are denied access to crucial social goods. Inequalities between individuals, groups and societies can be mapped in terms of the degrees to which love, care and solidarity are available respectively to each.

In the next five sections we trace the various dimensions of affective inequality as they have arisen in chapters 3-10 of this book. In so doing we demonstrate the depth, complexity and multidimensionality of affective inequality, as well as its gendered character and the ways it is reinforced by inequalities in other social systems. The affective system does not operate in structural isolation. It influences the operation of the political, economic and cultural systems, insofar as it enables or disables people to engage in those fields, be it by supporting them in love, care and solidarity terms or by failing to give support. The political, economic and cultural systems in turn, act back on

the affective system, by either enabling people to do loving and caring and to show solidarity, or by disabling them owing to lack of resources, power or respect and recognition.

Inequality in the Doing of Love and Caring: the Gendered Order of Caring

Perhaps the most widely recognised fact about the doing of love and caring, referred to repeatedly in this book, is the gendered division of labour and the consequent inequality between women and men in the dimension of working and learning. Not only do women do most of the paid care work, they also do most unpaid care and love work. The patterns are the same in Ireland (Lynch and Lyons, 2008) as they are in other OECD countries (Bittman et al., 2004). The cultural system plays an important role in maintaining this inequality, most obviously in the way that it sets out and enforces gender roles, imposing on women the primary responsibility for caring and enforcing this role with a sense of moral obligation). Our findings confirm those of other feminist scholars, namely that unpaid family caring exists as a social space where women are the default lovers and carers unless there is no suitable woman available (Gerstel and Gallagher, 2001; Noonan et al., 2007). Even where couples actively attempted to parent on an equal basis (Geraldine & Donal and Clodagh & Sean, see chapter 5), the persistence of the gendered attitudes of others (including family, friends and childminders from the crèche) made it virtually impossible to put this into practice. Because primary care work is indispensable, it has to be done for survival and development, and because women are not only socialised to do it, believing it to be in their nature, but morally sanctioned for failing to deliver on family love and care (O'Brien, 2007 and chapter 8), the affective system plays a

major role in generating gender inequality in society. This finding confirms our hypothesis in *Equality* that the affective system is a site of social relations that needs to be problematised if equality of condition is to be achieved, especially between women and men.

To understand why women are the default carers, lovers and solidarity workers in society, one must understand their relational other, men, and especially men's relationship to caregiving. What the Care Conversations study shows, and what is confirmed in Hanlon's research (chapter 9), is that care giving is culturally encoded as feminine and as such it is an identity that most men actively avoid (Russell, 2007; Simpson, 2004). None of the heterosexual men who were fathers and living with partners saw themselves (nor were seen by their partners) as the primary carers of their children. The men who were primary carers (of parents) had only taken on this responsibility because of their marital status (single), family status (son who inherited the family home/land with parents) and unique economic circumstances: two were able to combine care with some paid work (small farming) or held another legitimating public status (disability). While Hanlon found that some understandings of caregiving are sanctioned as masculine activities (notably caring as providing for others through breadwinning), this conception of caring only reinforced hegemonic masculine identities, as it was premised on the assumption that women (and children) are dependent on men. One of major reasons that women continue to do the care, love and solidarity work in society is because men fear that doing it will define them as feminine, and therefore inferior to other men. The fear of caregiving arises from a fear of association with femininity (Bourdieu 2001).

Being a man is about being in command and control, it is not about being a carer. The primary carer status is a vulnerable one, and it is proscribed in the hegemonic masculinities code (Connell, 1995). Where men do identify with care roles organisationally, it is as managers of caring, roles in which they can avoid the more mundane and burdensome activities of caring (Russell, 2007). Even when working in female-dominated occupations, including caregiving, they symbolically distance themselves from feminised and subordinated activities (Simpson 2004).

The irony of men being care commanders is that they are less likely to have opportunities to engage in the more emotionally involved aspects and forms of caring relationships. So although they are advantaged in status, power and income terms by defining themselves as breadwinning carers (chapter 9), they can receive less care as they define themselves outside of needing it.

Inequalities in Receiving Care: the Role of the Political System  
The political system plays a pivotal role in determining the conditions for loving and caring in society as the affective system is highly regulated legally by the state. Laws proscribe certain forms of sexual contact and prescribe ideal family forms (Freeman 1994; Nussbaum 2000; O'Donovan 1989). Legal discourse also helps to construct gender identity by applying notions of the 'good mother' (Biggs 1997) or 'good father' in custody disputes, the 'deserving housewife' or homemaker in family property disputes (Smart, 1989). Law both reflects and constitutes social relations, it promotes certain ideals at the expense of others (by for example, telling us what types of 'families' deserve recognition) and plays a powerful role in shaping and regulating the form of care that a person receives.

In our Care Conversations, we found that in the primary family care sphere, love is an assumed food on the table of emotional life. The young teenagers with whom we held focus groups took the care and attention of their parents as a given (chapter 6). It was something that was assumed and was not the subject of discussion or debate; it was deemed to be natural and inevitable. Notwithstanding this, Feeley's interviews with adults who had been in institutional care, and who had been neglected and/or abused in care, showed, however, how neither love, care nor solidarity can be assumed in life (chapter 10). Her research with survivors of institutional abuse showed how adults had experienced inequalities of care, not only in primary care, but also at the secondary and tertiary levels, due to neglect by guardians, teachers and the state respectively. The state had defined them in their childhood as only needing the most basic forms of protection (and even failing in that); they inherited the morally suspect identities attributed to their parents and with it a profound lack of love, care and solidarity. Their neglect in love and care terms had a huge impact not only on their emotional lives and relationships but also on their learning; most had left institutional care with a profound sense of emotional neglect, a neglect which seriously impeded their literacy learning.

## **Inequalities of Resources and the Impact of the Economic System**

Inequalities of resources, originating for the most part in the economic system, have a profound effect on what they enable carers to do and care recipients to receive. These are compounded by cultural norms about family status that assume households with children are couple households, and increasingly, that they are couples with two incomes.

Social class is especially important in structuring affective inequalities.

From the Care Conversations it was evident that those who were well-educated and had relatively high and secure incomes, such as Debra and Alex and Nuala and Elizabeth, had choices about how they organised their care world (Folbre, 2006). They could not only pay for supplementary care for their children, they also had the resources to call on supportive family care as needed. Low income carers and lone carers, be they caring for children or adult dependents, were heavily burdened in care terms, especially in the absence of affordable and accessible care-support services. While couple households could and did share care responsibilities, no matter how unequal that division of care may be, no such option existed for sole carers. Those who were sole carers of children and few economic resources, such as Sasha and Regina, had little independence of life; they experienced social isolation, stress, lack of leisure and general exhaustion. Those who were unpaid family carers of adults, including Melanie and Anita, were especially burdened by caring if they were poor and without supports (chapters 5 and 7). The demands of caring were exacerbated by a lack of hope of an independent future, and the challenge of living within an uncertain time frame.

O'Brien's study (chapter 8) shows how the lack of resources, including economic, cultural and social capitals, all impacted negatively on one's ability to care for children and adults in the way that one would choose to do. Pauline's lack of economic capital precluded her from making any choices about the schools her four children attended, while in Laura's case it led to constant

anxieties about unforeseen costs for schooling that she could not afford. In the Care Conversations (chapter 5), Tom also found the hidden costs of caring for his father very burdensome, while Melanie was physically and mentally exhausted from undertaking her multiple care responsibilities on a very limited budget. The lack of economic capital did not just have direct costs, it had indirect costs in terms of the emotional resources required to do love labouring. O'Brien found that mothers' emotional capital was depleted through having to manage a deficit of economic capital. In this context, even those with cultural capital, such as Masha, were unable to activate this capital in the interests of their children, because they lacked social or economic capital.

Both the Care Conversations and O'Brien's study show that the experience of one parent carers is especially challenging (Oliker, 2000). Not only was the cost of child care premised on the assumption that it is funded from a double-income household budget, but lone parents also had to manage the emotional and social isolation that was part of being a lone parent family. Emotional energy was also expended in managing the stigma that was often part of the single parent experience. Being poor and a lone parent confounded one's difficulties, as a lack of resources meant one was tied to caring mentally and emotionally, if not physically, all of the time. The one parent families with young children with whom we spoke had not availed of paid child care as they could not afford it.

While lone parents with young children struggled to manage care and paid work, or care and welfare, or paid work, care and education, they saw this as a

clearly defined phase of life no matter how arduous. Carers of dependent adults, including Mary, Nora and Melanie, did not hold this view. They could see no definite end to their caring lives, lives that were often seriously constrained by lack of supports and services for those on low income. Caring for adult dependents, without adequate respite and care-support services, was seen as arduous and stressful. Carers outlined the constraints it imposed on them in terms of their health, income, pension, sleep, leisure and quality of life generally, findings which concur with those from similar studies (Bittman et al., 2004).

The moral obligations to care built into our culture's construction of kinship ties sometimes impose severe costs on family members particularly on women and/or those who are single and without child dependents . We are not suggesting that this sense of family obligation should be done away with, but we do want to point out the way in which its destructive interaction with inequalities of resources could be significantly mitigated by a cultural shift that recognised a much stronger obligation on the part of society generally to support the care of all vulnerable members. As noted in chapter 1 care needs to be reconstituted as a public good. Responsibility for ensuring that care work does not lead to poverty and social exclusion should be taken out of the private sphere and reframed as a collective responsibility. Under this re-negotiated 'social contract' each individual engaging in caring labour would have a range of socio-economic rights met by the state, rather than by family member (see Becker, 2002 and Fineman, 2003 for further discussion).

## Interdependency and Inequalities of Power

Because men are culturally defined as care commanders and women as care's footsoldiers, men exercise a silent power over women in relation to the day-to-day work involved in primary caring (chapter 7). To expect a man to be a primary carer is to ask him to operate outside the accepted masculine gender code prescribed for men (Connell, 1995); it is, in many respects, to ask him to stop being a man. Some of the men we spoke with (like Seán) had never thought about the subject of care or discussed it, although they did do care work. Alex typified men who were clear that they did not want to be primary carers and who regarded being a primary carer as 'not the done thing' for men like himself (chapter 5). Primary caring was defined by most men and women as essentially women's work, and only a small number contested this binary code (chapter 5). Men exercised an implicit power over women's caring and loving capabilities therefore, and the time they devoted to loving and caring, not through personal command, but through the power of the moral imperative on women to be primary carers, and the complementary masculine imperative that men only do primary caring when women are not available.

Although care is often viewed as an asymmetrical relationship between a care giver and a care recipient, it is almost always also a relationship of interdependency, mutuality and trust (Hansen, 2004; Strazdins and Broom, 2004). We cannot draw a neat dichotomy between carer and care receiver as if each were at polarised ends of giving and receiving love and attention. No matter how limited the reciprocity may be care relations have a reciprocal dimension, even if it is giving or withholding a nod or a hand to show appreciation on the part of a

vulnerable care recipient. Where care is given within families or defined communities, care relations exist over protracted periods of time, and reciprocity may also occur inter-generationally rather than between particular pairs of care givers and recipients. Relations of mutuality and reciprocity within care relations are not always visible to the outside observer, however. In the Care Conversations, Mary, who was widowed, spoke affectionately about the value of the company of her intellectually disabled son, for whom she was the primary carer, while Regina spoke about how she enjoyed the company of her thirteen year old son for whom she was the sole carer. Anita (who was autistic) spoke about her love for her mother and Beth reciprocated, talking about how much she enjoyed her daughter, even though she also found care for her very demanding. Tom also conversed at length about the fun he had at times with his father and the satisfaction he got from caring for him so well (Chapter 6).

The interdependency of intimate relations impacts on how power works within the primary care sphere. While the carer does exercise power over the care recipient, and this is one of the reasons that disability researchers emphasise the importance of reducing unnecessary care dependencies for disabled people, it is a power that is tempered by cultural mores and conventions, by the survival needs of dependents, and by an assumption of trustworthiness that is often central to individual identities. Care is not always given on the carer's terms, not least because of the power of the care recipient to refuse certain forms of care and because of the cultural mores that exist in relation to care. People who are very vulnerable due to illness or infirmity can and do

show appreciation for care or fail to show it; they can call on culturally available moral imperatives to enforce their care expectations, especially in relation to women (Bubeck, 1995; O'Brien, 2007). This was very evident in Valerie's and Maeve's cases where both their mothers made it clear to them that they did not want to go into a nursing home.

Monica, who was in her 80s and needed some care support, also spoke about how she pressed her daughter (especially) into caring for her when she was ill. Although she felt guilty about that, she could not help making demands at the time as her fear of leaving her own home and entering nursing home care was so great.

The imperative to care is not just culturally defined, it also arises from the deep dependency that characterises relationships between the carer and the very vulnerable; the command to care arises from having to provide for basic needs. The profoundness of the vulnerability of an intimate other calls forth a level of attention that may not be desired by the carer. Moreover, the failure to meet the survival and elementary care needs of vulnerable dependents is highly visible and this visibility also exercises its own control on carers. So while vulnerability can and does allow for the carer to exercise power over the care recipient, it also enables the care recipient to exercise some unspoken power over their carers as the neglect or abuse of care recipients can and does become visible often within a short time.

Love labourers are expected to be trustworthy and committed over extended periods of time. They do not do care work on a hire and fire basis like paid care labourers and as such are bound by sets of long-term expectations. Care recipients, on the other hand, exercise control over carers through the 'trust fund' that underpins the primary care relations; it is this trust fund that generates

guilt, guilt on the part of carers that they are not doing enough and on the part of the care recipients that they are expecting too much.

### **Respect, Recognition and Love Labouring**

The impact of cultural values on caring is not confined to gender. We found two very different evaluations of caring, one in the public sphere and the other in the personal domain. In policy-making, employment and formal politics, carers and care recipients are not highly valued except at a rhetorical level. Most of those with whom we held conversations spoke about how politicians and employers did not respect their care responsibilities (Chapter 4). They felt that their caring lives were secondary in the eyes of the state and of most employers. They believed that the paid work world is *care-less*, in the sense that it does not have to accommodate caring unless legally required to do so.

All types of carers felt invisible and undervalued in their various forms of care work; they felt that care came last in the public order of priorities. Those who had been denied not only love, but also the secondary forms of care that were supposed to be provided for them by educators and by the state, were also aware of the lowly value placed on their care needs by most other adults (chapter 10). They felt robbed of part of their life and incapacitated by their love and care losses.

Within the interpersonal world, however, love, care and solidarity work was highly valued and protected, often at a high personal cost to the carer. The life world of caring is a space where carers and care recipients verbalise the

value of love and care for themselves. Moreover, carers are not passive recipients of negative labelling. They articulate a strong resistance to the lowly public evaluation of caring; they contest the values of the public spheres that assume the presence of love and care work while ignoring its existence and importance (Chapter 4). People are willing and able to contest economic rationalities and to articulate the primacy of nurturing rationalities.

The data show how human beings live in affective relational realities, especially in their primary care relations; they have emotional ties and bonds that compel them to act as moral agents, to act ‘other wise’ rather than ‘self wise’ (Tronto, 1991, 1993). Their lives are governed not only by the demands of economically and politically determined survival, but also by the rules of lay normativity (Sayer, 2005: 35-50).

### **The Social Scientific Implications of the Findings**

The findings from this work strongly endorse the message from ‘care feminists’, across the fields of economics, politics, law, sociology and social policy, that there is a need to redefine the understanding of the social scientific person from one that centres on the public persona, the economic, political and cultural actor in the public sphere, to one that recognizes that people are endemically dependent and interdependent.

It highlights the fact that if we are concerned about the well being of individuals in general, and gender equality in particular, we can no longer afford to ignore the significance of the affective dimensions of human experience. Human beings are at times autonomous, rational self-interested actors, but they are more than that. They are deeply

social creatures who are part of a complex matrix of social and emotional relations that often give meaning and purpose to life, even though they can also constrain life's options.

### *(a) Relational Identities*

The data show that primary carers, be they of dependent adults or children, defined their caring responsibilities as a core feature of their personal identities. This was especially true for mothers, whose lives revolved around their care responsibilities in a way that did not apply to fathers. However, whoever became primary carers, and sometimes they were men, also found their lives centred to a considerable degree on their love and care-related tasks. To say this is not to deny the importance of paid employment in defining personal identities (and the need to do paid work to earn a livelihood) but merely to note the importance of other-centred identities paralleling paid work identities. As noted in chapter 4 priority was frequently given to love labouring work when major conflicts arose between it and career and income gains, especially by women.

The narratives of primary carers were characterised by a discourse of nurturing that was distinctly oppositional to the narratives of competition that pervade the public sphere both locally and globally (Coulter and Coleman, 2004; Boltanski and Chiapello, 2007). Narratives with respect to caring for children were focused on their happiness in the present and their security in the future; among those caring for adults and older people, the focus was on respecting their wishes and desires for comfort or for presence. Care recipients also defined themselves in terms of the quality of the care they received (and some of these also did care work for others). While care was assumed as a given among teenagers, older people were aware that care was a desirable good that they could

not presume upon. The trust and attentiveness that was essential to good care was not assumed to be available in institutional care, either among carers or care recipients.

*(b) Nurturing Rationalities vs Economic Rationalities*

What is clear from all the studies reported in the book is that nurturing rationalities are different to economic rationalities. Almost all of the people with whom we spoke made some, and in some cases significant, economic and personal sacrifices in order to prioritise the care of those they loved. As most of those who were primary carers were women, most of the sacrifices were made by women (chapter 5). Debra took a job share arrangement to spend more time with her two children and in particular to care for her son with intellectual disabilities. Geraldine worked an early shift (being at work at 7 am) in order to have more time with her baby daughter in the evening; Maeve gave up taking in a student to supplement her income in order to care for her mother; Cathy moved to a lower paid job so that her husband and herself could have more time with their children; Jane took 6 weeks of unpaid leave in the summer in order to have time with her partner Jill and their two children; Tom and Tony devoted huge amounts of time to the care of their respective parents, and a sick uncle (in Tony's case), at a cost to their livelihoods and their social life; and Valerie gave up her prestigious career to be a full-time carer.

People struggled to find words to name their care labours, variously describing it as demanding, joyful, stressful, time consuming, fun, natural, exhausting and fulfilling; the lack of a language to name the different forms of care could be a study in itself (see Uttal, 2002). The named reasons for caring varied, although for any one person there were multiple motives; at times it was a sense of duty and obligation that was the primary

care narrative; other times the language of desire, longing and aspiration was more pronounced; the languages of guilt, hope, affection, responsibility and lack of choice were also dispersed throughout the interviews. Care was embedded in a set of relationships which had a history and an assumed future and so was integral to the sense of purposes, values and identities people held in life. To renege on *responsibility* for caring (even if some of the tasks had to be assigned to others) was to assign the person for whom one was caring an ‘unwanted’ caring status and to identity oneself as a person ‘who was not caring’. These reasons for caring were deeply embedded in people’s understandings of who they were, both as carers and as care recipients. Maeve, who was caring for her mother, exemplified this. She spoke about finding it difficult to care for her mother, who could be quite demanding, but whom she felt obligated to care for because of her sense of herself as a caring person, and because her mother would be deeply hurt if she was placed in residential care (see chapter 5 for further discussion of this).

Caring was not seen therefore as a discrete set of tasks that could be separated completely from the relationship in which it was embedded, and the identities of those involved. Because of this, only certain aspects of care could be handed over to others or paid for at times without undermining the relational identity of both carer and care recipient. Care is not just a practical dilemma about a set of tasks to be undertaken, it is also an emotional and moral dilemma about who one is relationally and what is best care. While there are cultural and classed responses to the dilemma of organising care as Duncan (2005) has suggested, our data suggest that people know that there are aspects to care, namely the love labouring dimension, which is inalienable. You cannot pay

someone else to build or maintain your own relationship with intimate others regardless of your social class, gender or other statuses.

*(c) Care as Work: A Focus on Love Labouring*

Most of the literature about care work treats it as a singular entity, classifying it largely in relation to the context or persons with whom it is associated, be it family care, institutional care, nursing care, home care, child care, elder care, etc. There is little understanding of which aspects of caring can be provided on contract and which cannot (Lewis and Giullari, 2005); the differences between secondary care labouring, which can be commodified, and love labouring, which cannot, are only minimally understood.

In chapter 2 we provided a taxonomy for discriminating different forms of care, one that differentiates not only between interpersonal forms of care that are alienable and inalienable, namely between secondary care labouring and love labouring respectively, but also between interpersonal forms of caring and inter-institutional and group-related forms of caring, that is between love and secondary care labour on the one hand and social solidarity on the other. While we provide the intellectual rationale for the distinction between these three forms of care in Chapter 2, most of the book is devoted to analysing the nature of one form of caring, love labouring, and exploring the equality issues that arise from the fact that this work cannot be commodified without being fundamentally altered and rendered as something else.

A major finding of the empirical studies on primary caring is that both carers and care recipients recognise the ways in which love labouring in particular cannot be assigned to others without altering the very nature of the intimate relationships involved.

The importance of the analytical distinction between what is and is not alienable in care terms, what we can pay others to do on our behalf and what we cannot, must not be underestimated. It means that there is a form of caring which assumes a long-term, personal commitment from the primary carer(s). The Care Conversations show that while paid carers are vital for assisting the love labouring, they cannot substitute for it. Feelings and commitments that are an integral part of an ongoing relationship are not available for hire. While paid care services were regarded as indispensable for supporting love labouring (and grossly under-funded and under-resourced), they were seen as supplementary to love labouring rather than a substitute for it. Parents could and did pay people to care for their children. However, they recognised that although paid carers built their own relationship with their children they could not replace the parents' relationship (Himmelweit 2005). Given the inalienability of love labouring, it was inevitable that primary care relations were deeply emotionally engaged, not only for carers but also, as shown in chapter 10, for those who did not have love invested in them.

Yet love labouring is defined as work by all of those who do it. It does not happen 'naturally' and effortlessly; it requires a huge investment of time, energy and effort. It is other-centred rather than materially productive work (although the latter depended on it to enable it to happen), but work nonetheless.

### **Implications for normative egalitarian theory**

In *Equality*, we distinguish between basic equality, liberal egalitarianism and equality of condition, each of which is defined in terms of the five dimensions already discussed. More specifically, we define basic equality as being concerned with basic protections

against inhuman and degrading treatment, including the most blatant forms of violence. We see liberal egalitarianism as concerned with the fair regulation of inequality by means of two pervasive ideas. First, there are stronger standards for the protection of the worst off, and, secondly, a commitment to some form of equal opportunity to succeed. We define equality of condition as a radically egalitarian objective that aims at overall equality in the conditions of people's lives. In contrast to liberal egalitarianism, that could be called a principle of 'equal outcome', but it is perhaps more accurate to call it the principle that, overall, people should be roughly equally enabled and empowered to live their lives.

The research discussed in this book helps to clarify and expand the understanding of these conceptions of equality in a number of significant ways. First of all, it supports the idea of a multidimensional understanding of equality, because it shows that inequality in the affective realm is itself multidimensional. If, therefore, we want to promote equality in the affective sphere we need to attend to all five of its dimensions.

Secondly, it demonstrates some of the interrelations between equality in one dimension and equality in others. For example, a very strong theme in chapter 4 was that the lack of material support for care givers was seen by them as expressing a lack of recognition for care-giving. This is clearly one way in which we cannot expect to promote equality of recognition without simultaneously promoting equality of resources. Similarly, it seems clear enough from the material discussed throughout this book that a shift in the gendered division of care labour, which belongs to the dimension of working and learning, is intimately connected with shifts in inequalities of recognition and resources. Greater equality of recognition and resources for care givers would be, in the

first instance, more beneficial to women than to men precisely because of the gendered division of care work, but this equality could itself have the effect of making care work more attractive to men. Conversely, one might reasonably hope that encouraging men to take on their fair share of care work would itself help to bring about greater equality of recognition and resources for care givers.

Thirdly, the research discussed here, particularly in chapter 10, invites a reconceptualisation of the dimension of love, care and solidarity. In *Equality*, this dimension was largely construed as concerned with providing and supporting positive relations of love, care and solidarity, and inequality was construed in terms of the differences between those who had access to these positive relations and those who did not. Little explicit attention was given to what may be called the negative counterpart of these relations – relations of hatred, abuse and social antagonism. Yet if there is an inequality of care between those who receive it and those who do not, there is clearly an even greater inequality in the same dimension between those who are cared for and those who are abused. We should therefore think of the range of the dimension of love, care and solidarity as extending in two directions and not just in one.

Fourthly, the research in this book raises some serious questions for liberal egalitarianism. A general feature of liberal egalitarianism is a commitment to some form of equal opportunity. One aspect of this position is the idea that social justice should be concerned with providing people with access to valued goods rather than to the goods themselves, because individuals should be free to accept or refuse the benefits they have access to. In the case of care, this distinction seems in many cases to lack any point. Children, the ill and the infirm need care itself; the idea of access is in these cases a

redundant concept. The carers featured throughout this book were not concerned with providing care recipients with ‘access’ to love and care but with love and care themselves.

Another aspect of the liberal-egalitarian emphasis on equal opportunity is the idea of personal responsibility: that people should be held responsible for the choices they freely make. The affective sphere raises serious issues for this stance. Does the ‘choice’ to provide care count as a free choice for which caregivers should be held responsible? This choice occurs within the context of a social system that, as we have seen, places family members, and particularly women, under a moral imperative to provide care. That they thereby feel ‘responsible’ for others is not just a play on words but shows that the concept of responsibility itself is more complicated than liberal egalitarianism tends to portray it. Moreover, the moral imperative to care and our responsibility for the care of others is partly constituted by people’s need for care. Is a socially mediated response to a need a free choice for which the responder should bear the costs? These are rhetorical questions because it seems clear enough that these needs must be met by someone if societies are to function at all and therefore are the responsibility of society as a whole and not simply of family members. But acknowledging this social responsibility makes the distinction liberal egalitarians emphasise between personal choice and brute luck extremely problematic.

A fifth problem that the research in this book poses for normative egalitarian theory is the issue of how to develop social norms and institutions in ways that are actually capable of satisfying the needs for love and care that the material here so amply documents. Egalitarian theorists have paid some degree of attention to how we might

design egalitarian economies, political systems, schools and even families, but these exercises have almost always been concerned with the other dimensions of equality. The key questions have concerned how these social institutions affect the distribution of income, wealth and cultural capital, how they generate or mitigate inequalities of opportunity, how well they can accommodate cultural and other group differences and the degree to which they can reduce inequalities of power. If love, care and solidarity matter then all of these institutional questions have to be revisited with a view towards assessing how well different institutions promote equality in this key dimension.

A central point of the research presented here is that certain kinds of care, what we call love labour, is inalienable and uncommodifiable. It may not always be possible to provide the love people need, but that does not make it any less of a loss. So in developing norms and institutions to deal with the issues of love, care and solidarity, it is going down an entirely wrong path to assume that all of this work can be allocated to public services or commodified for the sake of market-based providers. We are not denying that people contracted to care for others can also establish long-term loving relationships, but one cannot commit oneself by contract to love another, much less to do so on a life-long basis. In thinking about social norms and institutions, then, egalitarians must take seriously the objective of freeing both women and men from a level of commitment to paid work that is incompatible with meeting the love and care needs of others. This objective has wide-ranging implications for the economic system.

These points are related to a sixth question for egalitarian theorists, the question of rectification. As Anca Gheaus has argued (2005), failures of love and care are all too frequent in contemporary societies, and even the best institutional designs are imperfect.

These failures do not just harm people emotionally, but as chapter 10 in particular has documented, have huge effects on other aspects of their lives. Should we aim to compensate those whose needs for love and care have been frustrated? How? Egalitarian theory has paid some attention to compensation for lack of material resources, lack of opportunities and physical impairments, but apart from Gheaus's work, little attention has been paid to compensation for lack of love and care.

Finally, the research in this book helps us to understand how equality of condition should be defined in the affective sphere. In the dimension of respect and recognition, perhaps its most important lesson is that recognition can be very tightly connected with other dimensions of equality. In chapter 4, what came up time and again from care givers was the view that the true measure of the lack of regard others had for their role was the lack of material support they were given, irrespective of public expressions by politicians of what a fine job they were doing. Perhaps a further investigation would reveal other, more symbolic forms of expressing recognition for care but its material expression was central to the perspective of these care givers. This does not at all show that the dimension of respect and recognition is indistinguishable from that of resources, because it is clear from the Conversations that care givers felt deeply about the lack of recognition for their work and not just about its under-resourcing.

In the dimension of resources itself, the research discussed here deepens our understanding of the range of resources we need to take account of in promoting equality of condition in the affective sphere. There is plenty of evidence here that inequality in material resources has a very strong impact of people's ability to provide care, but the research reveals other resources that are also crucial. Chapter 8 in particular shows that

mothers' capacities to provide the care their children needed during the transition to secondary school were strongly influenced by their social capital, their cultural capital and their emotional capital, each of which influenced the others.

In relation to the dimension of love, care and solidarity, the research here contains a number of important insights. First of all, it confirms that this is a very important dimension of equality for many people. In particular, it is clear from the Care Conversations that many people prioritise relations of love and care over other dimensions of equality, and that they are therefore willing to incur low social esteem, poverty, powerlessness and lack of career prospects for the sake of maintaining their caring relationships. As mentioned above, it also shows that in many cases it seems pointless to characterise equality objectives in this dimension in terms of the opportunity for, access to, or capability for relations of love and care because what people in those cases need is love and care themselves, not just access to them.

The material in this book seems on the whole to confirm the model set out in Chapter 2 that distinguishes between primary, secondary and tertiary relations, although that model is intentionally schematic and allows for borderline cases. Most of the empirical work in this book concerns primary relations of care; there is some discussion of secondary relations but very little of tertiary relations. The characterisation of primary and secondary relationships given in Table 2.1 of chapter 2 is largely confirmed by the cases discussed in chapters 3-10, and so the material provides support for the idea that promoting equality of condition entails the kinds of commitment the Table lays out. Perhaps the greatest challenge to the model in chapter 2 is the claim discussed in chapter 9 that the 'masculine' mode of caring for others does not consist in the emotionally

intense, temporally prolonged and highly attentive activities set out in the Table 2.1, but in being the household breadwinner. Does this mean that our understanding of ‘love, care and solidarity’ should be extended to include the breadwinner relationship, or should that model of care be rejected? The problem with treating breadwinning as a mode of care is that it cannot substitute for the kinds of primary care that people need, but entails either that breadwinners will themselves have a ‘second shift’ as primary carers or that they will rely on and perpetuate a division of labour within the household that defines the care giver as a dependent and has played a central role in sustaining gender inequality. It is of course to be welcomed that people in paid work should apply some of their earnings to the care of their dependents, but that is not an adequate response to the need for care.

In Chapter 1, we raised the question of whether equality in people’s relationships of love and care was desirable, as distinct from being concerned with ensuring that everyone has access to the love and care they need. In the Care Conversations, care givers repeatedly spoke positively about the reciprocal nature of their relationships with those for whom they cared, whether these were young children or other family members, and even in situations where the care recipient was highly incapacitated. These remarks certainly show that people valued reciprocal love and care, although it is not constitute a full case for making reciprocity an important principle of equality.

The material in this book also illuminates the idea of equality of condition in the dimension of power. In large-scale contexts, radical equality of power is most straightforwardly conceptualised in terms of democratic political structures. In the affective contexts focused on by most of this book, namely families and other households, power relations are more subtle. In some cases, care givers clearly had

significant power over care recipients and many of those were situations – such as the care of young children or of incapacitated adults – where the power relationship was inevitably unequal. Even in cases where equal power is possible in principle, which in the case of children could be at quite a young age, there may obvious good reasons for unequal power. What's less obvious is the point discussed earlier in this chapter of the power that care recipients exercise over care givers, sustained by the moral obligations many caregivers feel and by broader social norms about the gendered division of labour. Here again, however, it was not always clear that equal power was a feasible alternative: if, for example, the care recipients were not really capable of abating their demands. Yet in such cases it is easier to see unequal power as an unavoidable wrong rather than a justified inequality. The social and moral norms governing caring are also a good example of the way impersonal, decentred power operates in the affective sphere. In this respect, the egalitarian ideal of equal power requires a deconstruction of those norms and their replacement by norms that are as far as possible equally empowering. This is not to say that no one should feel a moral obligation to care for others – quite the contrary. But it is to say that those obligations would not be oppressive in a society where caring was taken seriously and the burdens of caring were equally shared.

Finally, the material in this book helps us to clarify the idea of equality in the dimension of working and learning. There is ample evidence here that love and care do involve work. Although some respondents resisted that label, they did not deny that love and care were burdensome or that how love and care were arranged had an important effect on the extent to which their caring activities were satisfying and fulfilling or stressful and tedious. The evidence here also shows the persistence of the gendered

division of love and care labour, which most of the women were justifiably unhappy with. So the general idea that equality of condition requires access to satisfying and fulfilling work, whether it is paid or unpaid, together with a reasonably strong form of occupational equal opportunity, inconsistent with the gendered division of labour, is supported by the material in this book. What is more problematic is the sense so often expressed by care givers not just that they had no choice but to care, but also that they had a moral obligation to do so. Should we say that true equality in the dimension of working and learning entails that any sense of obligation is an infringement on freedom of occupational choice, and that everyone should be free to undertake love and care work or not, as they feel inclined? That does not seem to be a reasonable position, given that such work is a crucial and unavoidable condition for human survival, and therefore that we do have a collective obligation to ensure that it is accomplished. At the very least, then, everyone has an obligation to contribute to supporting love and care work. The stronger claim that everyone has at least a *prima facie* obligation to engage in such work is certainly suggested by the contribution such a universal obligation would make to eroding the gendered division of care labour, but the case for that claim needs to be further developed.

Overall, then, the empirical material in this book raises important issues for normative egalitarian theory. In some cases the implications seem fairly straightforward. In others, the material highlights questions that egalitarian theorists need to address.

## **Concluding Remarks**

This book set out to explore the subject of affective equality, focusing on the dynamics of care from an egalitarian perspective. It examined one particular dimension of care, namely love labouring, in depth: using data from four inter-related studies, it analysed the equality issues identified by a wide range of carers and care recipients related to love labouring in primary care relations. Love labouring, and associated care labouring, within families was examined from multiple perspectives, those of carers and care recipients, women and men, mothers and fathers, heterosexual and lesbian, older carers and young single carers, rich and poor, native Irish and migrant workers. The findings highlight the depth, complexity and multidimensionality, as well as the gendered character, of affective inequality. They demonstrate too the centrality of love labouring to personal identities, as well as its susceptibility to diminution owing to the lack of material supports, time and respect granted to it in the public sphere.

The studies also show how the affective system does not operate in structural isolation. It influences the operation of the political, economic and cultural systems, insofar as it enables or disables people to engage in those fields, be it by supporting them in love, care and solidarity terms or by failing to give support. The political, economic and cultural systems, in turn, act back on the affective system, by either enabling people to do loving and caring and/or to show solidarity, or by disabling them owing to lack of resources, power or respect and recognition. If, therefore, we want to promote equality in the affective sphere we need to challenge inequalities in all other social systems as well, namely the economic, the political and the socio-cultural. Without such a challenge, the

inequality of resources, respect and recognition, and power that were identified as demeaning love labouring will remain in tact.

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